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Re: Mental Health Services in Iowa

To Whom It May Concern,

I have been practicing psychiatry in Iowa since 1990. Over the last several years, inpatient beds have continued to diminish, and psychiatric units have been closing all over the state. It seems this trend will continue. We cannot remove services without replacing them with other services. If inpatient services will continue to shrink, we need more outpatient services. Specifically, we need **crisis intervention teams** and **walk-in clinics.** When I worked in New York City over 25 years ago, both of these types of services existed in order to prevent hospitalizations. I don't understand why, 25 years later, we still don't have such services available in Iowa. For two years I worked as director of a crisis intervention team in New York City. We were the gatekeepers to the local psychiatric hospital. Let me describe how each of the above two services functions.

A crisis intervention team takes referrals only from an emergency room where a patient has been seeking admission to an inpatient unit. Needless to say, the wait time should be under 24 hours, so that the team will most likely see the patient on the day after the ER visit, or on the next working day. The team will continue to see the patient daily for the next 4 or 5 times or until the acute crisis has been stabilized, and then the patient will be referred to regular outpatient services. The crisis team consists of a psychiatrist (or, in Iowa, more likely a psychiatric nurse practitioner) who directs the team and also prescribes medications. There are a few social workers on the team who provide both individual and family therapy. In some cases, if the patient worsens, the team may still end up recommending inpatient hospitalization.

The other type of service is a walk-in clinic. This service is intermediate between regular outpatient services and emergency/crisis services. It is intended for patients who are currently not receiving any mental health services, do not need emergency hospitalization, but neither can they wait for weeks to get a regular outpatient appointment. Here again, the patient will see a therapist and/or a prescribing clinician, on the same day he/she walks in to the clinic, and then weekly or twice a week thereafter, for about 3 or 4 times, and then be referred to regular outpatient services.

A major problem in Iowa has been the retention of psychiatrists. They leave Iowa to practice in other states. It does not help that Iowa ranks near the very bottom of states that have the lowest Medicare reimbursements. There are various other reasons for a general "brain drain" from Iowa which I cannot address here. Fortunately, there are more and more psychiatric nurse practitioners being trained to take the place of psychiatrists,

which is a good thing. I don't know what we would do without them. Chances are, they will become the leaders of the new teams I describe, if these teams ever materialize.

There are some specific issues that should be fairly simple to rectify. Before I mention them, let me address how and why the role of a psychiatrist has changed over the past several years. Many psychiatrists are no longer providing psychotherapy, because it can be done just as well by a highly trained social worker for half the cost, or by a psychologist for maybe two-thirds the cost. So many insurers will not even want psychiatrists to do therapy. That is fine with me. Psychiatrists therefore have become expert psychopharmacologists, and the bulk of their practice consists of prescribing medications and managing them, which has become increasingly complex with scientific advances. Psychiatrists as a group are becoming neuropsychiatrists. We manage more sleep disorders, migraine headaches, chronic pain, and Alzheimer's Disease than ever before. What we do is fundamentally different from what a therapist does. Yet, Medicaid will not reimburse for two different mental health services rendered on the same day. They will not pay for psychotherapy with a social worker and a visit with the psychiatrist on the same day, claiming it is a duplication of mental health services. This is how they keep costs down, but it is very short-sighted and ill informed. Needless to say, if crisis teams ever get off the ground, Medicaid will need to reimburse properly, realizing that two mental health charges on the same day is still far cheaper than hospitalization. **I therefore propose that Medicaid reimburse for each and every service, even if rendered on the same day.**

I also propose a change that should lighten the burden on psychiatrists who provide inpatient services. There should be a change to the Iowa Code which has to do with mental health commitments. Right now, when a patient (respondent) is under application for a mental health commitment, the court appoints a Chief Medical Officer to evaluate the patient and provide a written report to the court, as well as direct testimony at the time of the commitment hearing. The Chief Medical Officer is a physician, according to the Iowa Code. When this Code was legislated, there was no such thing as a psychiatric nurse practitioner. **I propose that the law be changed to allow psychiatric nurse practitioners to function in the capacity of Chief Medical Officers**. Under such circumstances, the testimony and court report of a psychiatric nurse practitioner should suffice to meet the requirements of the court in these matters.

I hope these ideas are helpful for a new direction for mental health services in Iowa.

Sincerely,

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